

described in Paragraph ~~(H)~~(J)(2) of this rule and the hospital care assurance match fund described in paragraph ~~(H)~~(J)(3) of this rule. Payments to each hospital shall be calculated as described in paragraphs (E), (F), (G), (H) and ~~(G)~~(I) of this rule. For purposes of this paragraph, the value of the hospital care assurance match fund is calculated as:

Sum of hospital care assurance program fund

$\{1 - (\text{Federal medical assistance percentage} / 100)\}$

The payments shall be made solely from the hospital care assurance program fund and the hospital care assurance match fund. If amounts in the funds are insufficient to make the total amount of payments for which hospitals are eligible, the department shall reduce the amount of each payment by the percentage by which the amounts are insufficient. Any amounts not paid at the time they were due shall be paid to hospitals as soon as moneys are available in the funds.

- (5) All payments to hospitals under the provisions of this rule are conditional on:
 - (a) Expiration of the time for appeals under the provisions of paragraphs (G) to (G)(4) of rule 5101:3-2-08 of the Administrative Code without the filing of an appeal, or on court determinations, in the event of appeals, that the hospital is entitled to the payments;
 - (b) The availability of sufficient moneys in the hospital care assurance program fund and the hospital care assurance match fund to make payments after the final determination of any appeals;
 - (c) The hospital's compliance with the provisions of rule ~~5101:3-2-07.17~~ 5101:3-2-07.17 of the Administrative Code.
 - (d) The payment made to hospitals does not exceed the hospital's disproportionate share limit as calculated in paragraph (D) of rule ~~5101:3-2-07.5~~ 5101:3-2-07.5 of the Administrative Code.
- (6) If an audit conducted by the department of the amounts of payments made and received by hospitals under the provisions of this rule identifies amounts that, due to errors by the department, a hospital should not have been required to pay but did pay, should have been required to pay but did not pay, should not have received but did receive, or should have received but did not receive, the department shall:
 - (a) Make payments to any hospital that the audit reveals paid amounts it should not have been required to pay but did pay or did not receive amounts it should have received;
 - (b) Take action to recover from a hospital any amounts that the audit reveals it should have been required to pay but did not pay or that it should not have received but did receive.
- (7) Payments made under paragraph ~~(H)~~(J)(6)(a) of this rule shall be made from the hospital care assurance program fund. Amounts recovered under paragraph ~~(H)~~(J)(6)(b) of this rule shall be deposited to the credit of the hospital care assurance program fund. Any hospital

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may appeal the amount the hospital is to be paid under paragraph ~~(H)(J)(6)(a)~~ of this rule or the amount to be recovered from the hospital under paragraph ~~(H)(J)(6)(b)~~ of this rule to the court of common pleas of Franklin county.

~~(H)(K)~~ Confidentiality.

Except as specifically required by the provisions of this rule and rule 5101:3-2-24 of the Administrative Code, information filed shall not include any patient-identifying material. Information including patient-identifying information is not a public record under section 149.43 of the Revised Code and no patient-identifying material shall be released publicly by the department of job and family services or by any person under contract with the department who has access to such information.

~~(H)(L)~~ Penalties for failure to report or make payment.

- (1) Any hospital that fails to report the information required under this rule and under paragraph (A) of rule 5101:3-2-23 of the Administrative Code on or before the dates specified in this rule and in rule 5101:3-2-23 of the Administrative Code shall be fined one hundred dollars for each day after the due date that the information is not reported.
- (2) In addition to any other remedy available to the department under law to collect unpaid assessments and transfers, any hospital that fails to make payments of the assessments and intergovernmental transfers to the department of human JOB AND FAMILY services on or before the dates specified in this rule or under any schedule for delayed payments established under paragraph ~~(H)(J)(1)~~ of this rule shall be fined one hundred dollars for each day after the due date, not to exceed more than twenty thousand dollars.
- (3) The director of job and family services shall waive the penalties provided for in paragraphs ~~(H)(L)(1)~~ and ~~(H)(L)(2)~~ of this rule for good cause shown by the hospital.

~~(K)(M)~~ Payment schedule.

The assessments, intergovernmental transfers and payments made under the provisions of this rule will be made in installments.

- (1) On or before the fourteenth day after the department mails the final determination as described in paragraph (G)(3) of rule 5101:3-2-08 of the Administrative Code, the hospital must submit its first assessment to the department.

All subsequent assessments and intergovernmental transfers, when applicable, must be made on or before the fifth day after the date on the warrant or electronic funds transfer (EFT) issued as payment by the department as described in paragraph ~~(K)(M)(2)~~ of this rule.

- (2) On or before the tenth day after the department's deadline for receiving assessments and intergovernmental transfers, the department must make a payment to each hospital. However, the department shall make no payment to any hospital that has not paid assessments or made intergovernmental transfers that are due until the assessments and transfers are paid in full or a final determination regarding amounts to be paid is made under any request for reconsideration or appeal.
- (3) If a hospital closes after the date of the public hearing held in accordance with paragraph (G)(2) of rule 5101:3-2-08 of the Administrative Code, and before the last payment is made,

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as described in this paragraph, the payments to the remaining hospitals will be adjusted in accordance with paragraphs (E) to ~~(H)~~(J)(7) of this rule.

EFFECTIVE DATE: August 3, 2001

RULE REVIEW DATE: 17 MAY 01, 17 MAY 06

CERTIFICATION: _____

DATE

PROMULGATED UNDER CHAPTER 119.

STATUTORY AUTHORITY RC SECTIONS 5111.02, 5112.03

RULE AMPLIFIES RC SECTIONS 5111.01, 5111.02, 5112.01 TO 5112.21

PRIOR EFFECTIVE DATES: 5/16/94 (Emer.), 7/24/94, 3/10/95 (Emer.), 5/18/95, 3/16/96, 8/7/96 (Emer.), 10/21/96, 11/1/97, 8/6/98 (Emer.), 9/18/98, 8/5/99 (Emer.), 9/15/99, 8/16/00 (Emer.), 9/28/00

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This rule is applicable for the program year that ends in calendar year ~~2000~~ 2001, for all medicaid-participating psychiatric hospitals as described in paragraphs (B), (C) and (D) of rule 5101:3-2-01 of the Administrative Code.

(A) Definitions.

- (1) "Inpatient days" means for each psychiatric hospital the number of INPATIENT HOSPITAL days as reported in the medicare cost report, HCFA 2552-96, worksheet S-3, part I, column 6 and the number of INPATIENT HOSPITAL days that would have been covered by medicaid if medicaid coverage were available to the population served age twenty-two to sixty-four.
- (2) "Insurance revenues" means for each psychiatric hospital the revenues received in the same twelve month hospital's cost-reporting period for inpatient services provided to, billed to, and received from all sources other than medicaid or self-pay revenues as described in paragraph (A)(4) of this rule.
- (3) "Medicaid inpatient utilization rate" means for each psychiatric hospital the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance AS DESCRIBED IN PARAGRAPH (A)(6) OF THIS RULE divided by the hospital's total inpatient days as described in paragraph (A)(1) of this rule.
- (4) "Self-pay revenues" means for each psychiatric hospital the revenues received in the same twelve month hospital's cost-reporting period for inpatient services provided to, billed to, and received from either the person that received inpatient services or the family of the person that received inpatient services.
- (5) "Total inpatient allowable costs" for each psychiatric hospital means the sum of the general service and capital related costs FOR INPATIENT HOSPITAL SERVICES reported in the medicare cost report, HCFA 2552-96, multiplied by the approved method to apportion the medicare to total costs as approved by the medicare intermediary.
- (6) "Total medicaid days" for each psychiatric hospital means the amount on the ODHS 2930, schedule C, column 6, line 35 and the number of days that would have been covered by medicaid if medicaid coverage were available to the population served age twenty-two to sixty-four.
- (7) "Total medicaid revenues" for each psychiatric hospital means the sum of the amounts reported on the ODHS 2930, schedule H, section I, column 1, line 8.
- (8) "Uncompensated care costs" means for each psychiatric hospital the total inpatient allowable costs as described in paragraph (A)(5) of this rule less insurance revenues as described in paragraph (A)(2) of the rule less self-pay revenues as described in paragraph (A)(4) of this rule less total medicaid revenues as described in paragraph (A)(7) of this rule less the uncompensated care costs rendered to patients with insurance for the services provided as described in paragraph (A)(9) of this rule.

- (9) "Uncompensated care costs rendered to patients with insurance" means the costs for an individual that has insurance coverage for the service provided, but the full cost of the service was not reimbursed because of per diem caps or coverage limitations.
- (10) "Charity care" means for each psychiatric hospital the total charges for inpatient services provided to indigent patients. It includes charges for services provided to individuals who do not possess health insurance for the service provided. However, charity care does not include bad debts, contractual allowances or uncompensated care costs rendered to patients with insurance as described in paragraph (A)(9) of this rule.
- (11) "Total charges for inpatient services" means for each psychiatric hospital the amount reported on the medicare cost report, HCFA 2552-96, worksheet C, part I, column 6, ~~line 10+~~ FOR INPATIENT HOSPITAL SERVICES.
- (12) "Total facility inpatient revenues" means for each psychiatric hospital the sum of the hospital's insurance revenues as described in paragraph (A)(2) of this rule, self-pay revenues as described in paragraph (A)(4) of this rule, and total medicaid revenues as described in paragraph (A)(7) of this rule.
- (13) "Cash subsidies for inpatient services received directly from state and local governments" means for each psychiatric hospital the amount of cash subsidies each psychiatric hospital has received from state and local governments as reported by each hospital in accordance with paragraph (C) of this rule.

(B) Applicability.

The requirements of this rule are limited pursuant to section 1923 of the Social Security Act, 42 USC 1396r-4.

(C) Source data for calculations.

The calculations described in paragraphs (D), (E), and (F) of this rule for disproportionate share payments for program year ~~2000~~ 2001, will be based on financial data and patient care data for psychiatric inpatient services provided for the fiscal year ending in state fiscal year ~~1999~~ 2000 and as reported by each hospital through a survey instrument as required by the department.

(D) Determination of disproportionate share qualifications for psychiatric hospitals.

Psychiatric hospitals will be determined to be disproportionate share if based on data described in paragraph (C) of this rule they meet either qualification described in paragraph (D)(1) or (D)(2) of this rule and meet the qualification in paragraph (D)(3) of this rule.

- (1) The hospital's medicaid inpatient utilization rate, as described in paragraph (A)(3) of this rule, is at least one standard deviation above the mean medicaid inpatient utilization rate for all hospitals receiving medicaid payments in the state; or

- (2) A low-income utilization rate in excess of twenty-five per cent, where the low-income utilization rate, the fraction expressed as a percentage, is the sum of:
 - (a) The sum of total medicaid revenues as described in paragraph (A)(7) of this rule, for inpatient services and cash subsidies for inpatient services received directly from state and local governments as described in paragraph (A)(13) of this rule, divided by the sum of total facility inpatient revenues as described in paragraph (A)(12) of this rule, and cash subsidies for inpatient services received directly from state and local governments as described in paragraph (A)(13) of this rule, plus
 - (b) Total charges for inpatient services for charity care as described in paragraph (A)(10) of this rule (less cash subsidies above, and not including contractual allowances and discounts other than for indigent patients ineligible for medicaid) divided by the total charges for inpatient services, as described in paragraph (A)(11) of this rule.
- (3) A medicaid inpatient utilization rate as described in paragraph (A)(3) of this rule greater than or equal to one per cent.
- (E) Determination of hospital disproportionate share groupings for payment distribution.

Hospitals determined to be disproportionate share as described in paragraph (D) of this rule will be classified into one of four tiers based on data described in paragraph (C) of this rule. The groupings for payment distribution are described in paragraphs (E)(1) to (E)(4) of this rule.

- (1) Tier one includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than twenty-five per cent but less than forty per cent or deemed a disproportionate share hospital based on a medicaid inpatient utilization rate as described in paragraph (D)(1) of this rule.
- (2) Tier two includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to forty per cent but less than fifty per cent.
- (3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to fifty per cent but less than sixty per cent.
- (4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate as described in paragraph (D)(2) of this rule greater than or equal to sixty per cent.
- (F) Distribution of funds within each hospital tier.

The funds available to each psychiatric hospital tier as described in paragraph (E) of this rule are distributed among the hospitals in each tier based on data described in paragraph (C) of this rule and according to the payment formulas described in paragraphs (F)(1) to (F)(4) of this rule.

- (1) A maximum of five per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier one as described in paragraph (E)(1) of this rule according to the process described in paragraphs (F)(1)(a) to (F)(1)(f) of this rule.
 - (a) For each hospital in tier one, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.
 - (b) For all hospitals in tier one, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.
 - (c) For each hospital in tier one, calculate the ratio of the amount described in paragraph (F)(1)(a) of this rule to the amount described in paragraph (F)(1)(b) of this rule.
 - (d) Multiply the ratio for each hospital calculated in paragraph (F)(1)(c) of this rule in tier one by the amount in paragraph (F)(1) of this rule to determine each hospital's disproportionate share payment amount.
 - (e) Each hospital will be distributed a payment amount based on the lesser of:
 - (i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or
 - (ii) The hospital's payment as determined in paragraph (F)(1)(d) of this rule.
 - (f) If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier four and be distributed in accordance with process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.
- (2) A maximum of twenty-five per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier two as described in paragraph (E)(2) of this rule according to the process described in paragraphs (F)(2)(a) to (F)(2)(f) of this rule.
 - (a) For each hospital in tier two, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.
 - (b) For all hospitals in tier two, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.
 - (c) For each hospital in tier two, calculate the ratio of the amount described in paragraph (F)(2)(a) of this rule to the amount described in paragraph (F)(2)(b) of this rule.
 - (d) Multiply the ratio for each hospital calculated in paragraph (F)(2)(c) of this rule in tier two by the amount in paragraph (F)(2) of this rule to determine each hospital's disproportionate share payment amount.
 - (e) Each hospital will be distributed a payment amount based on the lesser of:

- (i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or
 - (ii) The hospital's payment as determined in paragraph (F)(2)(d) of this rule.
- (f) If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four and be distributed in accordance with process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.
- (3) A maximum of forty-five per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier three as described in paragraph (E)(3) of this rule according to the process described in paragraphs (F)(3)(a) to (F)(3)(f) of this rule.
 - (a) For each hospital in tier three, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.
 - (b) For all hospitals in tier three, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.
 - (c) For each hospital in tier three, calculate the ratio of the amount described in paragraph (F)(3)(a) of this rule to the amount described in paragraph (F)(3)(b) of this rule.
 - (d) Multiply the ratio for each hospital calculated in paragraph (F)(3)(c) of this rule in tier ~~four~~ THREE by the amount in paragraph (F)(3) of this rule to determine each hospital's disproportionate share payment amount.
 - (e) Each hospital will be distributed a payment amount based on the lesser of:
 - (i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or
 - (ii) The hospital's payment as determined in paragraph (F)(3)(d) of this rule.
 - (f) If no hospitals fall into tier three, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four and be distributed in accordance with process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.
- (4) A minimum of forty per cent of the disproportionate share funds available to psychiatric hospitals as described in paragraph (H) of this rule will be distributed to the hospitals in tier four as described in paragraph (E)(4) of this rule according to the process described in paragraphs (F)(4)(a) to (F)(4)(e) of this rule.
 - (a) For each hospital in tier four, calculate the uncompensated care costs as described in paragraph (A)(8) of this rule.
 - (b) For all hospitals in tier four, sum all hospitals uncompensated care costs as described in paragraph (A)(8) of this rule.

- (c) For each hospital in tier four, calculate the ratio of the amount described in paragraph (F)(4)(a) of this rule to the amount described in paragraph (F)(4)(b) of this rule.
- (d) Multiply the ratio for each hospital calculated in paragraph (F)(4)(c) of this rule in tier four by the amount in paragraph (F)(4) of this rule to determine each hospital's disproportionate share payment amount.
- (e) Each hospital will be distributed a payment amount based on the lesser of:
 - (i) Uncompensated care costs as determined in paragraph (A)(8) of this rule; or
 - (ii) The hospital's payment as determined in paragraph (F)(4)(d) of this rule.

(G) Payments.

The department shall make payment in accordance with paragraphs (E) and (F) of this rule, for each psychiatric hospital described in paragraphs (B), (C) and (D) of rule 5101:3-2-01 of the Administrative Code that meet the criteria described in paragraph (D) of this rule.

(H) Disproportionate share funds.

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the Administrative Code from the state's disproportionate share limit as described in subparagraphs (f) and (h) of section 1923 of the Social Security Act, 42 USC 1396-r-4 (f), as amended.

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Rule review dates: _____

Certification: _____

Date

Promulgated under: Chapter 119.

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Rule Amplifies: Revised Code Sections 5111.01, 5111.02, 5112.01 to 5112.21

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5101:3-2-07.5 Disproportionate share adjustment.

This rule describes the disproportionate share definition and limitations on payment methods described in rule 5101:3-2-09 of the Administrative Code and assessment determinations described in rule 5101:3-2-08 of the Administrative Code for the program year specified in paragraph (A)(9) of rule 5101:3-2-08 of the Administrative Code.

(A) For the program year specified in paragraph (A)(9) of rule 5101:3-2-08 of the Administrative Code, paragraphs (B) to (D) of this rule set forth the definition of disproportionate share as well as other procedures and data used for the disproportionate share calculations and assessment determinations as described in rule 5101:3-2-08 of the Administrative Code and payment determinations as described in rule 5101:3-2-09 of the Administrative Code.

(B) ~~The source data used for the calculations made in paragraphs (A) to (D) of this rule and in rules 5101:3-2-08 and 5101:3-2-09 of the Administrative Code will be the hospital's cost-reporting period ending in the state fiscal year as specified in paragraph (C) of rule 5101:3-2-08 of the Administrative Code.~~ SOURCE DATA FOR CALCULATIONS.

(1) THE SOURCE DATA USED FOR THE CALCULATIONS MADE IN PARAGRAPHS (C) AND (D) OF THIS RULE WILL BE THE HOSPITAL'S COST-REPORTING PERIOD ENDING IN THE STATE FISCAL YEAR AS SPECIFIED IN PARAGRAPH (C)(1) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE.

(2) FOR A HOSPITAL FACILITY, IDENTIFIABLE TO A UNIQUE MEDICAID PROVIDER NUMBER, THAT CLOSES DURING THE CURRENT PROGRAM YEAR AS DEFINED IN PARAGRAPH (A) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE, THE COST REPORT DATA SHALL BE ADJUSTED TO REFLECT THE PORTION OF THE YEAR THE HOSPITAL WAS OPEN DURING THE CURRENT PROGRAM YEAR. THAT PARTIAL YEAR DATA SHALL BE USED TO DETERMINE THE DISPROPORTIONATE SHARE LIMIT FOR THAT CLOSED HOSPITAL.

(3) REPLACEMENT HOSPITAL FACILITIES.

IF A NEW HOSPITAL FACILITY IS OPENED FOR THE PURPOSE OF REPLACING AN EXISTING (ORIGINAL) HOSPITAL FACILITY IDENTIFIABLE TO A UNIQUE MEDICAID PROVIDER NUMBER AND THE ORIGINAL FACILITY CLOSSES DURING THE PROGRAM YEAR DEFINED IN PARAGRAPH (A) OF RULE 5101:3-2-08 OF THE ADMINISTRATIVE CODE, THE COST REPORT DATA FROM THE ORIGINAL FACILITY SHALL BE USED TO DETERMINE THE DISPROPORTIONATE SHARE LIMIT FOR THE NEW REPLACEMENT FACILITY IF THE FOLLOWING CONDITIONS ARE MET: (i) BOTH FACILITIES HAVE THE SAME OWNERSHIP, (ii) THERE IS APPROPRIATE EVIDENCE TO INDICATE THAT THE NEW FACILITY WAS CONSTRUCTED TO REPLACE THE ORIGINAL FACILITY, (iii) THE NEW REPLACEMENT FACILITY IS SO LOCATED AS TO SERVE ESSENTIALLY THE SAME POPULATION AS THE ORIGINAL FACILITY,

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AND (iv) THE NEW REPLACEMENT FACILITY HAS NOT FILED A COST REPORT FOR THE CURRENT PROGRAM YEAR.

FOR A REPLACEMENT HOSPITAL FACILITY THAT OPENED IN THE IMMEDIATE PRIOR PROGRAM YEAR, THE DISPROPORTIONATE SHARE LIMIT FOR THAT FACILITY WILL BE BASED ON THE COST REPORT DATA FOR THAT FACILITY AND THE COST REPORT DATA FOR THE ORIGINAL FACILITY, COMBINED AND ANNUALIZED BY THE DEPARTMENT TO REFLECT ONE FULL YEAR OF OPERATION.

(C) Determination of disproportionate share qualification.

- (1) For each hospital calculate the medicaid utilization rate by dividing THE SUM OF total medicaid days AND MCP DAYS as defined in paragraph (A) of rule 5101:3-2-09 of the Administrative Code by total facility days as defined in paragraph (A) of rule 5101:3-2-09 of the Administrative Code.
- (2) Each hospital with a medicaid utilization rate greater than or equal to one per cent qualifies as a disproportionate share hospital for the purposes of rule 5101:3-2-09 of the Administrative Code.
- (3) Each hospital with a medicaid utilization rate less than one per cent qualifies as a nondisproportionate share hospital for the purposes of rule 5101:3-2-09 of the Administrative Code.

(D) Limitations on disproportionate share and indigent care payments made to hospitals.

- (1) FOR PURPOSES OF THIS RULE, FOR ~~For~~ each hospital, calculate medicaid FEE FOR SERVICE (FFS) shortfall by subtracting from total medicaid costs, as defined in paragraph (A) of rule 5101:3-2-09 of the Administrative Code, total medicaid payments, as described in paragraph (A) of rule 5101:3-2-09 of the Administrative Code. For those hospitals exempt from the prospective payment system as described in rule 5101:3-2-071 of the Administrative Code, medicaid shortfall equals zero.
- (2) FOR EACH HOSPITAL, CALCULATE THE TOTAL MEDICAID SHORTFALL BY ADDING THE MEDICAID FFS SHORTFALL AS DEFINED IN PARAGRAPH (D)(1) OF THIS RULE TO THE MEDICAID MCP SHORTFALL AS DEFINED IN PARAGRAPH (E)(2)(d) OF RULE 5101:3-2-09 OF THE ADMINISTRATIVE CODE.
- (2)(3) For each hospital, determine the total cost of uncompensated care for people without insurance as described in paragraphs (D)(2)(3)(a) to (D)(2)(c)(3)(c) of this rule.
 - (a) For each hospital, "total inpatient uncompensated care ~~charges~~ COSTS for people without insurance" means the sum of the inpatient disability assistance medical ~~charges~~ COSTS, uncompensated care ~~charges~~ COSTS below the poverty level, and uncompensated care ~~charges~~ COSTS above the poverty level amounts from the ODHS 2930, schedule F, COLUMN 5, LINE 11.

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- ~~(b) For each hospital, calculate the total inpatient uncompensated care costs for people without insurance by multiplying total inpatient uncompensated care charges as defined in paragraph (D)(2)(a) of this rule times the inpatient medicaid cost to charge ratio as described in paragraph (A) of rule 5101:3-2-09 of the Administrative Code (D)(2)(b).~~
- ~~(c)(b) For each hospital, "total outpatient uncompensated care charges COSTS for people without insurance" means the sum of the outpatient disability assistance medical charges COSTS, uncompensated care charges COSTS below the poverty level, and uncompensated care charges COSTS above the poverty level amounts from the ODHS 2930, schedule F, COLUMN 5, LINE 15.~~
- ~~(d) For each hospital, calculate the total outpatient uncompensated care costs for people without insurance by multiplying total outpatient uncompensated care charges as defined in paragraph (D)(2)(c) of this rule times the outpatient medicaid cost to charge ratio as described in paragraph (A) of rule 5101:3-2-09 of the Administrative Code (D)(2)(c).~~
- ~~(e)(c) For each hospital, total uncompensated care costs for patients without insurance is equal to the sum of paragraphs (D)(2)(b)(3)(a) and (D)(2)(d)(3)(b) of this rule.~~
- ~~(3) For each hospital, calculate medicaid outpatient radiology services shortfall as described in paragraphs (D)(3)(a) to (D)(3)(c) of this rule:~~
- ~~(a) Using the medicaid claims payment system as the source of data, determine total charges for outpatient radiology procedures, for each hospital, for the time period corresponding to each hospital's fiscal year ending in the state fiscal year as specified in paragraph (C) of rule 5101:3-2-08.~~
- ~~(b) Using the medicaid claims payment system as the source of data, determine total payments for outpatient radiology procedures, for each hospital, for the time period corresponding to each hospital's fiscal year ending in the state fiscal year as specified in paragraph (C) of rule 5101:3-2-08.~~
- ~~(c) For each hospital, calculate the hospital specific outpatient cost to charge ratio by dividing total medicaid outpatient costs as reported in the ODHS 2930 by total medicaid outpatient charges as reported in the ODHS 2930, as described in paragraph (A) of rule 5101:3-2-09.~~
- ~~(d) For each hospital, determine total medicaid outpatient radiology costs by multiplying the ratio calculated in paragraph (D)(3)(c) by the amount in paragraph (D)(3)(a) of this rule.~~
- ~~(e) For each hospital, total medicaid outpatient radiology shortfall is equal to the amount in paragraph (D)(3)(d) minus the amount in (D)(3)(b) of this rule.~~
- (4) For each hospital, calculate the hospital disproportionate share limit by adding the TOTAL medicaid shortfall as described in paragraph (D)(1)(2) of this rule, RULE

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AND total uncompensated care costs for people without insurance as described in paragraph (D)(2)(c)(3)(c) of this rule, and outpatient radiology shortfall as described in paragraph (D)(3)(c) of this rule.

- (5) The hospital will receive the lesser of the disproportionate share limit as described in paragraph (D)(4) of this rule or the disproportionate share and indigent care payment as calculated in rule 5101:3-2-09 of the Administrative Code.

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Date

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